Testimony of Cambridge Health Alliance
Special Commission on the Health Care Payment System
February 6, 2009

Secretary Kirwan, Commissioner Iselin, and Commission Members: My name is Gerald Steinberg. Thank you for the opportunity to present testimony today on behalf of Cambridge Health Alliance (CHA) where I serve as Chief Medical Quality Officer and Senior Medical Director.

Before reviewing specific ideas about payment reform for the future, we think it is essential that the current assessment of today's baseline health care reimbursement system continue. As a major disproportionate share hospital and mental health provider, CHA aligns with the testimony presented by the Alliance of Massachusetts Safety Net Hospitals and the Massachusetts Association of Behavioral Health Systems.

Recent news accounts have provided insights into the disparity that currently exists in private and public reimbursements across providers and services. Strengthening the baseline reimbursement for many providers and services is a foundational step that needs to be taken prior to implementing new and innovative payment methods. For example, episode-based payment for mental health services is one approach for consideration, however, current baseline mental health rates across all payers do not adequately cover the actual costs of providing this care and would need adjustment.

This Commission's work is very important as we seek to sustain Massachusetts health reform's gains in coverage and, especially in this economic climate, realize best value for our health care dollar. This is an opportunity to evaluate health care processes and outcomes that are valued, and then construct the payment system to support those values. At Cambridge Health Alliance, we value a primary care based health system. Such systems are widely regarded as an efficient and equitable way to improve health, reduce the burden of illness, and optimize the use of resources devoted to health care.

The payment reforms we recommend focus on creating a payment system for cost effective improvements in the health of our populations through a stronger, team based, primary care practice within a "medical home " that is integrated within a delivery system. In this context, new payment methods need to support health maintenance, team based care, valuing of patients with complex behavioral and social needs, and also encourage primary care training. Success will require shared accountability regarding outcomes and cost.

PAYMENT MODELS FOR PRIMARY CARE, CHRONIC DISEASE MANAGEMENT IN THE MEDICAL HOME

- Today's health care financing system is largely driven by fee-for-service, with greater reimbursement tied to procedure-based, complex care, and proportional to the number of services provided. This volume driven system does not address the need for alignment of incentives between providers and payers, or between revenue and outcomes. A new payment system must support the transition from volume to value, and create the alignments that increasing numbers of stakeholders recognize as essential.
- We recommend consideration of reforms that align financial incentives with the goals of better prevention, wellness, coordinated patient-centered care, best outcomes, and optimal utilization. These reforms should include enhanced payments for primary care, chronic disease management, and integration of mental health and substance abuse services. This is somewhat new terrain, with some progress thus far but no ideal system. However, based upon what has been learned a variety of approaches could be considered, tested, and demonstrated.
- CHA has some experience in these efforts beginning in 2001 as one of several sites involved in a national Robert Wood Johnson Foundation initiative. We implemented a team based Planned Care Model for Chronic Disease across our primary care sites to improve outcomes for patients with childhood asthma, adult diabetes, and depression.
- Our work for children with asthma illustrates the important gains that can be made in improving health, reducing avoidable hospitalizations and emergency room care, and, ultimately, cost savings. As a result of this program:
    - Inpatient admissions for children enrolled in the asthma program decreased 90%, from 9% in 2001 to 1.2% at the end of last year (N=2,455).
    - Emergency department use declined 65%, from 20% to 7% during the same period, improving the patients' health while saving payers the costs of the avoided inpatient stays and emergency department visits.
    - It is worth noting that these payer savings were lost revenues for hospital based care that CHA did not have the opportunity to provide. Please understand that we are fully committed to care that keeps patients well. This is noted only to illustrate the lack of alignment between current payments and quality of outcomes.
- In addition, many primary care activities we provide today that are essential to health improvement are non-reimbursable under the current system. These include care coordination for chronic disease, increased access for patient visits, culturally and language appropriate visits, physician-directed group visits, phone or personal outreach to hard to reach populations, and other team based functions essential to good care.
- To achieve the goals outlined above, we support a "medical home" platform. Episode-based payments, global payments, and modified capitation with quality-focused pay-for-performance features are payment systems worthy of consideration, but it is critical that we be thoughtful in regard to risk and risk sharing given providers' limited ability to bear risk at this point. This is especially true of safety net providers.
- Demonstration models might be the best next step. CHA has some of the infrastructure and clinical expertise necessary to implement such models. We have an integrated primary care based delivery system along with sizable patient panels covered in public programs (Medicaid, Medicaid Managed Care, Commonwealth Care, and Health Safety Net Fund). We also are linked to a provider-sponsored safety net health plan (Network Health). CHA is

interested in partnering to further develop and demonstrate these new models for our patient population.

CURRENT PAYMENT SYSTEM CASE-MIX DOESN'T REFLECT RESOURCE INTENSITY

- Whatever new models are considered, careful review of the "sensitivity" of the current payment system is needed. While there are national efforts to improve the validity of traditional case-mix payment adjustments, these efforts do not address the resource intensity required for and the "social complexity" of safety net populations. Patients who lack means and face complex life circumstances like homelessness require extra social work, outreach, and cultural or linguistic support. These aspects of health care are crucial to good health outcomes and deserve support.
- The current case-mix system for mental health and substance abuse, in particular, doesn't work. These services are categorized as "low case-mix" even though the resource intensity is high, and increasingly patients present with multiple diagnoses, including mental illness and substance abuse together, and concomitant medical conditions.
- In addition, these case-mix systems figure into Medicaid, Commonwealth Care and Health Safety Net Fund rate development. As referenced above, case-mix system based Medicaid inpatient rates do not reflect the actual costs for core secondary care provided by disproportionate share hospitals and many community hospitals. The Health Safety Net Fund is based on the Medicare model, which does not adequately reimburse for the high proportion of outpatient care utilized by the uninsured and for mental health services.
- This places an added financial burden on disproportionate share providers with concentrated roles in caring for underserved populations who depend on government health care.

GME PAYMENTS SHOULD BE DIRECTED TOWARD PRIMARY CARE

- Finally, if we value a primary care based system, it's important to have attractive and sustainable primary care training; otherwise, we will not have the necessary clinicians to build a system more dependent on primary care. After trainees finish their education we also need to be able to provide adequate compensation.
- Medicaid graduate medical education payments have historically been tied to that portion of physician training that is done in the inpatient hospital setting. A significant proportion of the training for primary care is located in outpatient settings and, therefore, goes unreimbursed in the Medicaid GME reimbursement. CHA has recently expanded its primary care residency program by 24 Family Medicine residents, yet this is not appropriately recognized in current reimbursement.

Thank you for the opportunity to present testimony. Cambridge Health Alliance is committed to be a partner in this work and is available to Commission members for follow-up.